WIGSTON CENTRAL SURGERY

Two Steeples Medical Centre

10 Abington close, Wigston, Leicester, LE18 2EW

Telephone: 0116 2882566

Website: www.wigstoncentral.co.uk



Child Registration Form (under 16 years)

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| **FOR OFFICE USE ONLY**  **Date Form Received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff Initials: \_\_\_\_\_\_\_\_\_\_** |
| **ID Shown  TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

Thank you for applying to join Wigston Central Surgery. We would like to gather some information about the child and ask that you

Fill in the following questionnaire. Please complete all appropriate fields. **You will need to supply a form of Identification**

**with this completed form, for example child’s red book, passport or birth certificate**

**Fields marked with an asterix (\*) are mandatory.**

|  |  |  |  |
| --- | --- | --- | --- |
| \*Title | \*Surname |  | \*First names |
| \*Any previous surname(s) (if applicable) | |  | \*Date of Birth **DD / MM / YYYY** |
| \*Male Female | |  | \*NHS No. |
| Town and country of birth | |  | \*Home address |
| \*Parent/guardian telephone No. | |  |  |
|  | \*Postcode |
| **Please help us trace their previous medical records by providing the following information** | | | |
| \*Previous address in the UK (if applicable) | |  | Name of previous doctor |
|  | |  | Address of previous doctor |
| Postcode | |  |  |

**If they are from abroad**

|  |  |  |
| --- | --- | --- |
| \*Their first UK address where they registered with a GP if they were previously living abroad |  | \*If previously a resident in the UK,  date of leaving |
|  |  | \*Date they first came to live in the UK (if applicable) |
| Postcode |  |  |

**Is the child a looked after child?**

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| A child who is being looked after by their local authority is known as a child in care. They might be living with foster parents, at home with their parents under the supervision of social services or in a residential children’s home.  **\*Is this child a looked after child? Yes**   **No**  **Who has the legal responsibility for the child?**  **Who can consent for the medical treatment of the child?** |

**Additional details about the child**

|  |
| --- |
| What is their ethnic group?  **White**  British  Irish  Other White (please specify):  **Black**  Caribbean  African  Other Black (please specify):  **Asian**  Indian  Pakistani  Other Asian (please specify):  **Mixed**  White & Black Caribbean  White & African  White & Asian |

**Main spoken language**

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| --- |
| What is their main spoken language? |

**Data Sharing (Electronic Data Sharing Module)**

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| **Sharing out of data:**  Do you consent to the sharing out of data recorded on the child’s GP record with other organisations that may provide care for them? This means that other organisations can see/access their notes to better any care needed.  **Tick this box if you wish to opt-in**  **Tick this box if you wish to opt-out** |

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| **Sharing IN of data:**  Do you consent for the GP practice/clinicians to be able to access/view any information/data recorded by other care services about care the child has received? (eg. Hospital admissions, nurses visits etc)  **Tick this box if you wish to opt-in**  **Tick this box if you wish to opt-out** |

**Information and Communication Needs**

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| \*Does the child have any communication or information needs due to disability, impairment or sensory loss? (if yes please specify)  \*Communication or information method required i.e. braille |

**Carers Information**

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| Is the child looked after by someone whose support they could not manage without?  Yes No If YES what are their contact details?  Do you consent for their carer to be informed about your medical care? Yes No |

**Next of Kin/Emergency Contact**

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| Name / Relationship to child / Telephone Number: |

**Medical Details**

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| \*Is the child allergic to any medicines?  Yes  No (if yes please specify) |

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| \*List other allergies (pollen, animal hair or certain foods. Please state “none” if you have no other allergies. |

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| Does the child have any underlying serious illnesses?  Yes  No (if yes please specify) |

**Does the CHILD or THEIR FAMILY have history of any of the following? If yes please state who.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **High Blood Pressure** | Yes | Who |  | **DVT / Pulmonary Embolism** | Yes | Who |
| **Ischaemic Heart Disease**  Diagnosed aged >60 yrs. | Yes | Who |  | **Breast Cancer** | Yes | Who |
| **Ischaemic Heart Disease**  Diagnosed aged <60 yrs. | Yes | Who |  | **Any Cancer**  Specify type: | Yes | Who |
| **Raised Cholesterol** | Yes | Who |  | **Thyroid disorder** | Yes | Who |
| **Stroke / CVA** | Yes | Who |  | **Epilepsy** | Yes | Who |
| **Asthma** | Yes | Who |  | **Osteoporosis** | Yes | Who |
| **Diabetes** | Yes | Who |  | **Other (Please list)** | | Who |

**Communication Preferences**

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| \*Do you consent to receive the following types of communication from Wigston Central Surgery regarding the child?  **Email** Yes No  **Mobile phone text messages** Yes No  **Answering machine messages** Yes No  **Letter** Yes No |

**GP Online Services – Patient Online Access**

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| Once the child’s application to join our practice has been accepted you’ll be able to order their repeat medications, book appointments and view certain aspects of their medical record via the internet. This service is known as **SystmOnline,**  **If you would like to request a nominated pharmacy for their medication please specify here………………………………………………..**  **………………………………………………………………………………………………………………………………………………………………………………………………**  Once the child is a fully registered patient of our practice you can visit www.wigstoncentral.co.uk to begin their Patient Access registration. This service is available to everyone with a valid email address. ***We can only accept your request for Patient Access if your email address is valid and NOT shared by another person.***  ***Would you like to use SystmOnline?***  Yes  No  If yes, please specify the e-mail address you wish to use for GP Online access \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  When the child’s application to join the practice has been processed we will post to you your **SystmOnline** details. |

**Summary Care Record**

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| **Summary Care Record (SCR)**  As the child is registering with this practice, we would like to recommend that they take advantage of the Summary Care Record (SCR). It includes important information about their health: Medicines they are taking; allergies they suffer from, any bad reactions to medicines  **You can also choose for the child** to have additional information included in their SCR, which can improve the care they receive. This information includes: Their illnesses and health problems; operations and vaccinations they have had in the past; how they would like to be treated – such as where they would prefer to receive care; what support they might need; who should be contacted for more information about them  They may need to be treated by health and care professionals outside of the practice who do not know their medical history. Having the additional information SCR can help the staff involved in their care access information more quickly, allowing them to make informed decisions about their healthcare. **More information can be found by visiting www.nhscarerecords.nhs.uk**  **Tick this box if you wish to opt-in to the Core SCR**  **Tick this box if you wish to opt-in to the Core an Additional SCR**  **Tick this box if you wish to opt-out of the SCR** |

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| **Please record any additional information about the child that you think is important for us to know** |

|  |  |  |
| --- | --- | --- |
| **\*Signed on behalf of child:**  **\*Relationship to child:** |  | **\*Date DD / MM / YYYY** |

**Once you have completed your form…**

If there are any problems with the child’s registration we’ll contact you to clarify any issues otherwise we aim to have them

registered with the practice within 5-10 working days.

Reviewed May 2021 by KP Review date: May 2022

Wigston Central Surgery